MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 12, 2002
10:14 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
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RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
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DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Framework for assessing payment adequacy -- Jack Ashby, Ariel Winter, Ann Marshall

MR. ASHBY: With this session we begin the annual process of developing our update recommendations, and those recommendations that generally comprise the bulk the material for our March report to Congress.

As we see in this first overhead, we are planning to develop recommendations for eight fee-for-service sectors this year. The first six that you see there are the same as we dealt with last year. And then we are going to try our hand at developing updates for two new sectors this year, hospice and ambulatory surgical center.

As most of you remember, last year we developed a new system for assessing payment adequacy and updating payments. This year we're looking to refine that system to some degree. So this morning I'm going to be explaining how the system works and in the process discussing some of those potential refinements.

Then when you've had a chance to ask questions and discuss these methodological issues, Ann Marshall and Ariel Winter will be on to present some trends in fee-for-service spending across the sectors that we will be assessing.

As you see in this first schematic, our system calls for asking two basic questions and asking them sequentially. The first is is the current base rate too high or too low? Followed by how much will efficient providers' costs change in the next year? Each of these processes results in a percentage change factor, and then we simply sum the two percentage change factors to result in the update.

As you notice, in the last step before finalizing our recommendation, we will be comparing the figure that the model calls for to the update in current law. That's sort of a new addition to this outline of our process and we'll talk a little bit more about that later.

For the first part of the process, this is assessing the adequacy of current payments, this next schematic shows that we have three steps. In short, we're estimating where we are now, then assessing whether this is the right place to be, and then adjusting accordingly. So I'm going to walk through each of these three steps, returning to the list of market factors and policy factors that you see here as we go along.

So now we're in the first part of the process, assessing the adequacy of current payments, and looking at the first step in so doing, which is to estimate our current payments and costs.

We have to realize that the word current here is somewhat of a misnomer. Since we are recommending updates

for the 2004 payment year, the current year refers to 2003 and the government fiscal year 2003 doesn't even start for two more weeks. So right off we are left with having to project out one year to find out where we stand.

Then if CMS' cost report data system is operating well, we would be forced to project for a second year because it takes a year to process the date. So we always have at least one additional year of lag.

But since the data system is backed up at the moment due to a raft of policy changes they've had to accommodate the last couple of years, we are in the position at least for this year, of having to project for a third year. So we have a three year lag between data that we have on hand and the so-called current year that we're trying to estimate.

Just as an aside, next year at this time the CMS people tell me that we should have picked up a year. So that in next year's process we will be projecting only two years rather than three. But that doesn't help us at the moment.

The last point here is that the analysis also takes into account other policy changes that are scheduled to be implemented in 2004. The idea here is to start with base figures that capture the effect of all policies that providers will be facing in 2004, except the update which is our subject decision. An example of a policy that is scheduled to go into effect in 2004 is the sunsetting of the hold harmless provision for small rural hospitals in the outpatient PPS.

In the next we look at the appropriateness of our current cost. We, unfortunately, have no direct indicator of whether the cost basis is appropriate, whether it represents costs of efficient providers in the absolute. But we can at least look at the trend in cost per unit of output. All else being equal, we would expect the growth in cost per unit of output to approximate the growth in the market basket. But that expected rate of cost growth can be affected by product change, such as the major decline in length of stay that we experienced in the hospital sector over the last decade. When length of stay falls, we would expect growth in cost per unit of output to rise less than the market basket. How much, of course, is not an easy question, but at least this is the concept.

If we believed, in the end, that costs were too high or too low going into our assessment, we would probably want to adjust those costs before deciding whether payments are adequate relative to costs. The best example of this issue is actually from the past. Our predecessor commission, ProPAC, declared several years running during the late '80s and early '90s, that cost growth was

essentially excessive and that consequently our update recommendations were not going to stay up with the rate of cost growth.

This may be an issue that we'll want to examine this year, at least in the post-acute care sectors.

Then once we're comfortable with the cost base, the next step is to assess the relationship of payments to costs. And in doing this, we look at the market factors that we have listed here. As just one example, if we see a substantial increase in the number of providers, that may indicate that payments are too high. And conversely, if we see a substantial number of providers close or stop accepting Medicare patients, that may be an indicator that payments are too low.

Along with those market factors, we also have to consider this one policy factor: the target relationship of payments to cost. If we had a standard relationship here, expressed as a margin, it certainly would make our job easier. If we estimated a base margin that's above the standard, we'd know the payments are too high and vice versa. But after some considerable discussion, we've concluded that a fixed standard is not going to be feasible here.

For one thing, the appropriate relationship is a function of the risk that provider face, and certainly that varies all over the map. It varies from provider to provider, by sector, and probably by sector over time.

Besides that, we have to remember that if we believe that these market factors that we just looked at do influence the adequacy of payments, then we have to be prepared to respond to evidence of changes in those factors.

So the bottom line is that we have no practical alternative but to have the Commission decide on the appropriate relationship of payments to cost, or a range in that relationship, one sector at a time and one year at a time.

The last step is to adjust current payments if we were to find that current payments were too high or too low. Usually this would take the form of a simple plus or minus percentage factor applicable to all hospitals. But it could well be combined with a distributional payment change, as was the case in at least three of our sectors last year, the hospital inpatient SNF and home health sectors all had recommendations that combined distributional changes with the update.

But just to clarify, if the distributional change that we are contemplating will have no impact on overall payments, that is if it's being done budget neutral, then there's no point in muddying the waters by bringing it into our update discussion.

But if the distributional change would also increase or decrease the amount of money in the system, which is often the case, then it's really quite important that we do take it into account in developing our update, because it's the overall amount of money in the end that we're trying to make a decision about.

Moving to the second part of the process, accounting for provider's cost changes in the coming year. The most important factor here is the expected change in input prices which CMS measures and forecasts out to the payment year with a market basket index. The actual payment update will be based on that forecast, although the forecast that we have available to us now will not necessarily be the final one that determines payments next October.

But in addition to input price inflation, we also consider the impact of quality enhancing but cost increasing technology and we expect that at least part of the cost of that new technology can be offset through productivity gains. And we may also consider the cost of one-time factors as we did with the 2000 computer problem.

Basically, the Commission has to decide whether it is appropriate to assume that the cost of technological advancement can be offset completely by productivity improvement. We may wish to do additional analytical work or to search out the research of others if we have reason to believe going in that we are looking at a situation where the impact of technology costs might be substantially different from what we can reasonably expect in the way of productivity improvement.

A special consideration we now have in accounting for cost changes in the coming year is the new technology pass-through payments which apply in both the hospital inpatient and outpatient sectors. Now these payments were intended to be temporary. They are to operate for two to three years while CMS collects data with which to permanently adjust the rates.

By law the pass-through payments are to be made budget neutrally. Actually, that wasn't done initially with the outpatient pass-through, but it's the way the law reads and as far as we know it's the way the pass-through are going to be administered from here on out.

An important factor then is that this means that the extra payments that are going out for cases where these technologies are used will be offset by lower payments in all other cases. Because there, in the end, is no increase in overall payments, it remains necessary to account for the cost impact of new technology in our update framework. Basically, the same as always.

But we are left with a situation where the data from the pass-throughs, the unit cost and the utilization of

all of these specific technologies, gives us data that we've never had before for doing our assessment. And that should, by all means, be useful in deciding whether the cost impact of new technology exceeds what we can reasonably expect with productivity growth. So we're going to make an attempt to use those data in that way this year.

Back in the initial schematic, we noted that before finalizing our recommendation we would consider current law. This begins with simply noting what the legislated update is for the payment year, and actually we have always done that. But we think that we also should be aware, as we make our decisions, and actually state in our report, how spending under our recommendation would differ from spending under the current law provision.

That raises a host of questions about our approach for doing this, how we would estimate the impact, how we would coordinate with CBO and the like. We're going to take up some of those issues at a later meeting.

But finally, we think that we should also ask whether there's sufficient reason to change current law. For example, if our model suggested an update of market basket even and current law called for market basket minus a half or market basket minus one or something, is the current law level within the range of what we consider adequate payments? And as a consequence, is there sufficient reason to change what is in current law?

That approach may lead to stating our conclusions and recommendations relative to the current law. A statement such as current law provides an adequate payment increase, or perhaps something like current law is at the high end of our range of payment increases we believe would be adequate, or something along that line. We have occasionally expressed things in that form. It hasn't been our usual approach, and it's something that we might want to consider as we go along.

The last issue that we wanted to cover is handling policy objectives other than our primary one, which is to ensure that Medicare payment rates cover efficient providers' unit costs.

In the current PPS', the best examples of payment provisions that pursue other objectives are first, a disproportionate share adjustment, which is designed to protect the financial viability of hospitals that treat low income patients. And second, the indirect medical education adjustment, supporting the activities of teaching hospitals through a portion of the IME that exceeds the measured effect of teaching.

A similar issue arises when other payers' rates differ substantially from the cost of treating their patients. A couple of very current examples are Medicaid

paying well below cost for nursing facility services, and private payers paying unusually high rates to rural hospitals.

After some considerable discussion the Commission's outlook on this general issue is that other policy considerations should be essentially confined to policies that affect the distribution of payments. And the implications of that statement are twofold. One is that our decision, the decisions that we have forthcoming in the next several meetings, are decisions about the overall payment adequacy, how much money should be in the system, should not consider other payer policies, particularly since responding to other payer's rates risks influencing their rate making.

But then secondly, the implication is that the funds for the IME and the DSH adjustment, or any other payment adjustment that pursues a different objective, must be included in overall payments as we assess payment adequacy.

So that's our system, and some of the things that we have in mind for operating a little bit differently this year. We probably want to open up discussion now on this, before we turn to the trends.

MR. HACKBARTH: Jack, I have a question about efficient providers. As you know the House passed a Medicare bill that has language saying that we should explicitly take into account efficient providers. And implicitly, if not explicitly, we had basically said, I think, that the efficient provider is the average. Because we look at average margins as our indicator of financial performance, recognizing of course that there's a range around that average. Sometimes we look at the distribution and not just the average itself.

On what basis do we conclude that the average is efficient? Or maybe to put it in another way, you alluded to the fact that ProPAC, at an earlier point, had specifically reached the judgment that the average increase in at least some years was not efficient and therefore the update should not accommodate that.

How did ProPAC decide that the average was not efficient in those years?

MR. ASHBY: They basically did what I think we are stuck with doing, the best that can be done, and that is looking at the trend. We look at the rate of cost increase and if it differs from the market basket increase, which is what you would get if everything remains constant and we accommodate inflation in the items that providers must by, if the rate of increase is higher than that -- or for that matter, if it's lower, you sort of have to ask why.

Is there a justifiable reason for seeing costs growing at faster than what inflation would accommodate?

Then we have to look at the factors that we've talked about in our update system. Is there reason to believe that the growth in technology really needs to be higher?

There was once a question of whether wage inflation would be higher than in the market basket because of some problem in how the market basket was constructed. Various factors we can look at like that to attempt to explain why cost growth would be higher. But in the end, if we don't see any justifiable reason, then we have to conclude that we are getting into the territory where the average cost base is getting too large.

But I think that general approach is about all that we can really do.

MR. HACKBARTH: So basically we're assuming that in a system where there is an incentive to hold down your cost, you receive a financial reward for holding down your cost, and when you have a mature system that's been in place for a long time, you assume that everybody's trying to do as well as they can financially. And so the average is pretty efficient after a period of time.

MR. ASHBY: Right, in a competitive market in a situation where providers are under major pressures from all payers, you would expect that situation to unfold.

DR. NEWHOUSE: I think your final question did hit the nail on the head in terms of the incentives, but I would just note there's a couple of conceptual problems with our language about efficient provider.

One is that there is some presumption of what the quality of services is. We now know that staffing ratios, for example, seem to correlate with the rate of errors. Well, that means that I can be efficient given some rate of errors or given some staffing ratio, but what do I want? Rolls Royce may be efficient at producing Rolls Royces, but maybe I don't want to pay for a Rolls Royce.

The second issue, I think, about using the average, implicit in some people's use of that anyway may be that there are some people that are more efficient than the average. And if we're really serious about paying for the efficient provider, then we should be looking at somebody that's lower cost than the average.

The corollary to that is if we pay less than the average, we risk putting people out of business, which we may want to do, particularly since the average that we're looking at is the national average and implicitly we're operating in a great many local markets. If we're really serious about the efficient providers, really the efficient provider in that local market, but the system isn't set up in a way that easily accounts for local price variation.

So I think we are back to where you ended up, that the inherent incentives in the system are what we rely on

here.

MR. MULLER: Jack, have we looked back over a reasonable period, three or five years, to see how the cost increases and the volume increases and maybe the residual in which you can throw a lot of things like technology and so forth, have compared to our estimates, to get a sense of how well our estimates or anybody else's estimates actually come to what is seen as the cost increase after the year of the buy increase?

I know that in the tables we have here, where we looked at the expenditure increase -- I think it's just being a little bit below nine for the 2001 year -- we said we weren't able yet to kind of parse that out and see how much of that was volume and how much of that was cost and other factors.

Is that something that we do routinely, where we look at a multi-year period to see how we come up against --

MR. ASHBY: Absolutely we do, and the hospital sector in particular we have, in general, been looking back about 10 years or so because of the major transformation in the system that's occurred over that period. But keep in mind that when we look at spending information, and you talk about the 9 percent increase, that includes volume and this is a per case or per unit of output system.

So generally, we're looking at the rate of increase in per unit costs and the rate of increase in payments per unit. And the payments and the costs per unit are generally what we're looking at with our margin, for example. So when we look at these trends, even in the margin over time, that's what you're looking at is whether the payment increases have stayed up with the cost increases.

MR. MULLER: I understand that fully. But obviously when volume is changed in any dramatic way, either up or down, it has an effect on expenditures. And some people tend to confuse that with being cost increases. So to the extent to which one can point out -- in fact, one can hypothesize that costs may go up one and volume goes up seven. And then people don't differentiate that very well.

So I think the fact that -- one of the implications of the technology breakthroughs that everybody is worried about what they cost, is also there are many more opportunities now to do interventions than there were prior to those technologies. So that leads them to more and more activity increased. And that's one of the reasons I'm interesting in seeing how much of the technology gets played out, in terms of activity increases, versus just in terms of cost increases per unit.

The aggregate of activity, I think, becomes substantially important in addition to the individual per

case.

MR. ASHBY: Absolutely. It's certainly part of the landscape and, as we said when we listed our factors we're looking at, volume changes are indeed one of them. So we do want to consider it. But in the end, this is a per unit payment system and we need to look and track per unit costs, as well. And then we get into the larger picture which we need to keep in mind, as you're saying.

DR. REISCHAUER: It seems to me futile to look back and ask whether we've been right or wrong because in the end the provider will adapt to whatever payments they have to produce a service, and they will adapt by changing the quality, changing staffing ratios, whatever you have. So unless you are going to look very carefully at some kind of qualitative measures or changes in the way inputs are put together, you're never going to get really definitive ability to say yes, we hit the nail on the head or we were in the neighborhood of the nail even.

Maybe, over a long period of time, what we want to do is try and develop more measures or indicators of qualitative change.

I have another comment which is disassociated with that one, that has to do with technology. If I understand this correctly, the distribution among providers, hospitals in this case, is budget neutral.

MR. ASHBY: You're referring to the technology pass-through payments? Yes.

DR. REISCHAUER: Pass-throughs. But we are including it in our analysis. And so in the great schemes of things, it's not budget neutral.

MR. ASHBY: All I was trying to do is to remind people that since it's budget neutral, the system does not provide funding for new technology. And I think that's a misconception that a lot of people --

DR. REISCHAUER: But on the other hand we have provided it in our mechanism here.

MR. ASHBY: Right.

DR. REISCHAUER: So in a funny way the distribution isn't but the system is. I'm sort of wondering, are we schizophrenic here?

MR. HACKBARTH: It almost seems like if Congress has explicitly said that the pass-through must be budget neutral, to them, in a separate part of our analysis, our framework, say there should be an increase for new technology that is or is not partially offset by productivity. It just seems schizophrenic. It seems illogical and inconsistent to do it that way.

If we're going to have budget neutral technology, let's do it. If we're not, let's not. But to do different things in two parts of the analysis is odd.

MR. ASHBY: But I think the way to understand it, the key to understanding it is that the system that we work with here, and what we've been doing for years, is dealing with the level of payments. Pass-through payments are dealing with the distribution of payments. The level and the distribution are always two different things, but they tend to interact, causing us lots of nightmares and confusion.

But I think that we can see the potential benefit of distributing payments correctly here. Those providers that have to bear the cost of the new technology need to be paid appropriately for their cases. And so you can see the advantage of that.

But it's just that that, in and of itself, doesn't do anything to address the question of whether we've provided adequate funding for all of the new technology and everything else providers have to pay for.

DR. REISCHAUER: Forgetting about the latter, the budget neutrality, in a sense, guarantees in the distribution that we pay nobody correctly because what we've done is we've said hospital A uses new technology and it costs $100 extra. Hospital B doesn't. So we'll create this pass-through payment and then reduce everybody's payment by 9 percent. And so we're underpaying one and overpaying the other.

MR. ASHBY: I think you're correct in saying that. If we were confident --

DR. REISCHAUER: But then we're jacking up the total which would overcome this and make the payments wrong in another direction. And it strikes me that the logic -- I mean, to get ourselves out of the schizophrenic position we're in, what we should say is there's a chunk of things that we've identified for pass-throughs, and they're over here. But there's a whole lot else that's going on in the way of technological improvement. And that component should be what we are making this aggregate adjustment for.

MR. ASHBY: We could do that. If we didn't make it budget neutral and we just let payments increase with the new tech things then, as you say, all we would need to accommodate in our update is the impact of anything else that is not captured by the tech pass-through. For example, information systems would not, by definition, be captured by the tech pass-through.

MR. HACKBARTH: It would be helpful to me, if we were to go down that path if we would clarify what is technology A and what is technology B. What's covered by the pass-through versus what isn't covered by the pass-through. I don't know what's in the two categories.

MR. ASHBY: In generic terms it's limited to patient care applications. So as we say, by definition,

it's going to exclude information systems. And it is limited to major new technologies. It has to meet a threshold. But you always have the suspicion that there's a lot of small ticket stuff going on, too, that certainly can have its impact. So those are the two major ways that you are carving out a segment of the costs.

MR. HACKBARTH: Logically, if those are no longer included under our traditional S&TA adjustment, presumably that number should be lower than it has been historically.

MR. ASHBY: Right.

MR. HACKBARTH: What we've assumed it to be historically.

MR. ASHBY: Right. I think implicitly, what you could suggest is going on here is that we know that these technology pass-through payments, as a measure of the cost of new technology, are questionable at best. I mean, there are several different factors one could site that affect the accuracy of these payments.

So by making the system budget neutral, what Congress is really saying is that we're going to make sure that the level of payments is not distorted. If there's going to be any distortion, it's going to be on the distribution because they may overdo it on some things, which means that somebody else is going to be underdone.

MR. MULLER: But to go back to Bob's point, at the macro level we say that the productivity enhancement offsets the technology improvements, so it has a distributional aspect that you and Jack are talking about if it doesn't have an overall spending effect because we offset it on the analysis of the productivity adjustment; correct? The new technology.

DR. REISCHAUER: The question is, compared to what? If we had no cost-increasing technology change, we would expect not to give a full update. Or else we would be fattening the margins of providers. And so I think you want to compare it to that as the counterfactual.

MR. MULLER: But I'm just saying we just make an explicit assumption that technology equals productivity, don't we? We make the assumption that technology equals productivity.

MR. ASHBY: We can make that assumption.

MR. MULLER: We do make that assumption.

DR. REISCHAUER: We do that as a bow to our ignorance with respect to both of these factors, but imagine that we collect more data and there's more information on these pass-throughs, and five years from now we really have much better estimates for what? The cost increasing impact of technology is or much better estimates of productivity in the medical center is, and we find that these are different. One is .3 and the other is .9.

MR. MULLER: No, I assume they are quite different. I assume for the purpose of analysis we equate them, but I would assume that they are quite different. I don't have any evidence, aside from watching it for a while.

That's why I was asking about the activity increase earlier, because I think one of the ways in which you really see the technology hitting is through activity, not necessarily always through price. Because there are just more and more kinds of interventions that are possible to populations that weren't affected before.

DR. NEWHOUSE: Ralph, remember some of that will get picked up in the payment system because there will be a DRG code and there will be more admissions or procedures for that purpose, and there will be more payments without an adjustment in the update factor.

MR. ASHBY: I wonder if I can make a point to extend what Ralph is saying? And that is that I think the general picture is that on the hospital inpatient side, generally speaking, the new technology that is covered by the pass-throughs is not going to add additional activity in the form of cases. These are items that are used in producing these cases.

On the outpatient side, what you're saying absolutely prevails. That generally the new technology is going to produce new units of service and Medicare is paying for it. That means that how we treat the cost impact of technology may very well need to be different for inpatient payments than outpatient payments. And that's why we should not go around blithely saying that we're going to assume that the cost impact of technology will be offset by productivity, because it may or may not, depending on how this plays out.

MR. DeBUSK: What happens in this scenario? A lot of the new technology, the implants and what have you, certainly the manufacturers are going after the surgery center, the outpatient market. When you have a product that's being used in a hospital on a DRG basis, now with some new technology you can take it to an outpatient basis. And you reallocate the dollars to go with the activity on an outpatient basis and it's budget neutral. What does that do to the base dollars for the surgical procedures in the hospital? It's going to decrease them substantially as time goes along, right?

MR. ASHBY: Hospital inpatient you mean?

MR. DeBUSK: Yes.

MR. ASHBY: I don't know that there can be any fixed answer to that.

DR. NEWHOUSE: You mean the quantity or the price?

MR. DeBUSK: Price. I'm not talking about quantity. I'm talking about price because if you're budget

neutral, those dollars are going to come from someplace.

DR. NEWHOUSE: Not from that DRG. That's based on what's left in the hospital.

MR. DeBUSK: On what's left in the hospital. Yes, but the other procedures, budget neutral, it's going to come out of that whole market.

DR. NEWHOUSE: No, I mean what's left of that procedure in the hospital. If the whole thing shifts out of the hospital then it will just disappear.

MR. ASHBY: We do have to clarify, Pete, that budget neutral only means with respect to a given PPS, such as the outpatient PPS. It's not budget neutral for the entire enterprise worth of payments.

MR. DeBUSK: I understand.

MR. HACKBARTH: Jack, could I go back to the efficient provider discussion for a second? Bob made the observation that over time at least hospitals or other providers have to accommodate themselves to the payment level. And so if the payment levels are held way down, they need to adjust the services they provide or cost structure. And as Joe pointed out, that could include a change in the quality of the ultimate product.

If we look back at the historical pattern in hospital margins under PPS, we see peaks and valleys, some periods of very high margins, at least one of significantly lower margins. Has anybody ever looked back at that historical pattern and analyzed what hospitals did to accommodate themselves to those lower payment levels in the late 1980s when the average margin was quite low?

DR. NEWHOUSE: They upped their rate to private payers.

MR. HACKBARTH: Clearly, that was one thing that they did.

MR. ASHBY: First and foremost was to do that.

MR. HACKBARTH: But what about in terms of their cost structures?

MR. ASHBY: Second and foremost was to reduce length of stay and whether that was occurring with --

MR. HACKBARTH: What about staffing in particular?

MR. ASHBY: There's certainly evidence that there were some reductions in staff levels and other things that one might really call efficiency improvements if we had some notion that quality was constant, which we generally don't. But there was indeed some evidence that there was cost cutting going on in addition to the effects of length of stay reduction.

We don't have good measures of staffing ratios, but the cost data certainly would lead one to suggest that there probably were some reductions going on.

MR. HACKBARTH: In my little world in Boston at

the time, and I don't know how representative it was even of Boston let alone the rest of the United States, but there was a period of very contentious relationships between the hospital administration -- at a hospital that shall remain nameless -- and the nursing staff in terms of the conditions of work, the nursing ratios and the use of non-RNs to take over some of the tasks, et cetera.

Now subsequent research has shown that in fact there is a relationship between those ratios and the ultimate quality of care produced. If what was happening in my little piece of the world was representative of the larger world, maybe there were some quality issues then, some things happening in response to low margins that were reducing the quality of care offered.

Has anybody tried to look systematically at that?

MR. ASHBY: We have not.

MR. MULLER: The reference Joe made earlier to some of the recent analyses on staffing, and there was -- interestingly enough, about two weeks -- a new article in the British Medical Journal on staff turnover in nursing in British hospitals, where it was up to 38 percent, and having at a very crude level consequences on quality, which is pretty intuitive but also now seen in the outcomes data.

So I think, in retrospect, the notion that one could dramatically hold down staffing increases for a while, as a result of these cost pressures, and have no effect on quality, at those times people were suspicious that those hospitals could become that efficient overnight. And in retrospect, it seems as if it did have some effect on quality by doing so.

Whether one can afford to pay for all the things that people want is a question that we debate all the time. But the notion that you can just hold down staff due to cost pressures and have no effect on quality, I think in retrospect, seems to be quite suspect.

DR. REISCHAUER: This is on a different part of this. This is on the issue of including DSH payments when we evaluate payment adequacy. I guess my question is what the legislative intent of the DSH payments in Medicare are. I mean, are they to compensate for the excess costs associated with elderly and disabled patients? Or with the hospitals overall problem with respect to treating low income and underinsured patients?

Because if it's the latter, then there's an inconsistency with the way we're treating it. Because what we're saying is let's look at your payments, add in DSH, and then compare them to Medicare costs and get the Medicare margin. And if that's just right for DSH hospitals, then the payment is adequate.

But of course, it's leaving nothing for this

larger social purpose, if the large social purpose includes helping the hospital deal with low income patients in general. And if that's the case, then you might want to see margins in those hospitals, which get DSH payments -- Medicare margins, not total margins, Medicare margins -- higher than the average for the others. And of course you do, I know.

MR. ASHBY: Actually the other way that you can express that is that the hospitals that receive the DSH payments, if you look at them as a group, absolutely, they get more than an adequate payment for the cost of their care. So that the concern is the relationship for the hospitals that don't get the DSH payments. It is a distributional matter and so one might argue that there is some underfunding for that group of hospitals relative to efficient costs of care.

But that's what we buy into when we use this mechanism for distributing part of our payments. And no one ever suggested that we were adding in this additional amount of money into the system on top of what it would cost to provide care to patients. So I think that's kind of what we're stuck with, unless we want to recommend changing it.

MR. MULLER: But I think you just granted that Bob's second point was accurate, that these payments are -- not for Medicare patients, but for other patients. You just said that, right?

MR. ASHBY: Yes, but I didn't just make that up.

MR. MULLER: That's the law.

MR. ASHBY: It's not only in the law, but it is what the Commission has said in the past, as well, is that we believe that the purpose of this is to maintain access to care and to protect financial viability of hospitals that incur these revenue losses. Not extra costs, but essentially revenue losses.

MR. HACKBARTH: We should probably move on to the next piece of this. Carol, do you want to have the last word?

MS. RAPHAEL: Yes, I just have a question; something that would help me. I understand that we are in a very primitive state in regard to understanding productivity. But it would be helpful if we could just have a little amplification as to how we currently think about productivity in each of these sectors.

MR. ASHBY: That's definitely a hot seat question.

MS. RAPHAEL: Then I'm glad I have the last question here. We don't want to let Jack off too easy.

MR. ASHBY: Let me just say this, we have attempted in the past to measure the trend in productivity and we had repeated difficulties with it, much of which really centers around the fact that to really say you are

measuring the productivity or the change in productivity, you really have to know that you're holding the quality of care constant and there's virtually no way to do that. So the measurement process is extremely difficult and I don't know that I feel very optimistic about our ability to do that.

So in essence, what we have been doing, I think in all of the sectors, is saying that we want to expect a certain minimal growth in productivity and we're making that statement of expectation without regard to any measurement of what's been happening in those sectors. It's really just sort of establishing a standard. And the closest we've gotten to developing that standard in some quantitative way is to look at the change in productivity in the general economy. And we observed that, for total factor productivity, which as we talked about earlier we think is the right way to look at it, that the change is, at best, in the neighborhood of about .5 percent per year, in terms of our long-term trend in the economy. Now it changes a little bit from year to year, but not a great amount. That's generally what we're looking at.

But is that the right level for home health agencies or whatever? We really have no way to make that translation. We just have to establish our policy.

MR. HACKBARTH: The good news is we'll have many more opportunities to discuss these issues in the coming months. Right now we need to move on to the next piece of this presentation on trends in Medicare spending. Because we started a little bit late and ran over a little bit in the first part, we'll need to go through this fairly quickly.

MS. MARSHALL: Good morning. It's important to consider the payment adequacy framework that Jack has just discussed in the context of current payment levels and recent trends. Of course, the given level or trend does not itself tell you whether a payment increase or decrease is appropriate. However, this information should help you to understand at least three things.

First, the proportional impact of a proposed update. For instance, a small change in inpatient payment rates affects a large proportion of total outlays, whereas a large change in a sector such as dialysis affects a relatively small portion of total outlays.

Secondly, trends highlight how growth in one sector compares to growth in other sectors. Growth or decline in different settings may be related. For instance, distributional changes, as you know, may reflect substitution among settings.

And finally, large spending changes in any one setting may signal a problem with payment adequacy in that

setting.

Today we're presenting data on total fee-for-service Medicare payments, including both program cash outlays and beneficiary cost-sharing. We've divided the payments into the eight sectors that Jack and others will be examining, in terms of payment adequacy.

Out of a total of $240 billion in Medicare fee-for-service payments in 2001, by far the largest component, 43 percent, was hospital inpatient payments. This was followed by physician payments at 23 percent, and hospital outpatient department at 8 percent. Post-acute care, including skilled nursing facility and home health, accounted for 11 percent. These proportions have remained roughly constant over the last five years, with the exception of home health which has fallen from 8.5 percent to 4.4 percent.

Over the longer term, however, we have seen tremendous shifts, for instance from inpatient to outpatient and post-acute settings. In 1980, inpatient dollars accounted for 68 percent of payments compared to the 43 percent seen here. Hospital outpatient was 5 percent compared to the 8 percent here in 2001. Home health and skilled nursing facility combined for 4 percent compared to the 11 percent seen here in 2001.

Interestingly, physician services have remained relatively stable at 24 percent in 1980 and 23 percent in 2001.

For the period 1996 to 2001, the past five year trend, total Medicare fee-for-service payments grew at an annual rate of 3 percent. Of particular note are hospice and ambulatory surgical centers which saw significant average annual increases while home health experienced a significant decline.

Some year-to-year fluctuation is not reflected in this table. For instance, the BBA caused total fee-for-service payments to fall slightly in 1998 by approximately 3 percent. However, by 2001, payments increased at 12 percent growth, primarily due to BIPA and BBRA provisions and a shift of Medicare+Choice enrollees into fee-for-service.

In fact, this 3 percent average annual increase for this five year period is an anomaly and it's important to know that growth rates are historically been much higher and are projected to be higher in the future, as this next slide shows.

This longer term trend reveals a historical 10 percent average annual increase for the period 1985 to 1997 after early PPS implementations and prior to BBA implementation.

The trend reflects increases in payments pre-BBA until 1997 with flatter growth rates post-BBA until year

2001. And then around 2001, payment rates increase again and are projected to increase at an average annual rate of approximately 6 percent between 2002 and 2011.

Of course, it should be noted that these rates of change -- this has already been discussed this morning -- reflect a host of underlying dynamics such as changes in volume, price, and intensity of services. These other factors and their implications for payment adequacy, access to care, and quality of care will be discussed over the next months by MedPAC staff. In our background materials at Tab C, staff have summarized key payment adequacy issues they will address in this regard this year.

In conclusion, to provide commissioners greater context in which to consider their recommendations, in future meetings, staff will review additional spending and budgetary information. This will consist of Medicare expenditures compared to national health expenditures, private payer premiums, and other government health program spending such as Medicaid, information on health care spending and trends including projections from sources such as OMB, CBO, and the Medicare trustees report, budgetary surplus or deficit projections, and underlying demographic trends that impact spending, such as an aging population.

Thank you and we welcome any questions or comments.

MS. ROSENBLATT: I think looking at these trends is great and I think one of the comments you made is really important, that you're going to try to disaggregate the trends so that you're looking at cost trend, utilization trend, demographic trends.

But one of the things I'd like to see is looking at trends on a per beneficiary basis, as well as just straight dollars.

DR. REISCHAUER: Just a footnote on that, what's striking about that second chart is that this is just fee-for-service and so you obviously have the overall growth in the Medicare population, which is something around 1 percent. And then you have the shift of people from Medicare+Choice into fee-for-service.

So you probably, on a per participant, could lop almost 2 percentage points off of these numbers, which suggests that over the last five years, in some categories, that they've been basically flat.

And these are nominal dollars?

MS. MARSHALL: Yes.

DR. REISCHAUER: So in real dollars you've seen probably a decline in many of the areas.

MR. HACKBARTH: With a recent acceleration.

DR. NEWHOUSE: That was the intent of BBA, given where we were in '96.

MR. HACKBARTH: The 6 percent per year increase that's in the projection going forward, that of course presumes current law, which in turn assumes that we will cut physician fees by a very large sum over the next few years, and some other features of current law that may or may not be sustainable.

So if you mentally add those things back in, then the rate of increase projected going forward is now substantial. So we have this period where rapid increase, then this decline, and then rapid increase again.

MS. ROSENBLATT: Just one other point on that disaggregation. The trustees' report disaggregates a lot of the trends into cost versus utilization and various aspects of utilization. I think it might provide a very good way of looking at how you might want to look at trends, as well.

MR. HACKBARTH: Any other questions or comments on this?

MR. DURENBERGER: Just one and that is, looking at this from a beneficiary standpoint, rather than the money to providers, I would find it interesting to know more about the cost rise in Medigap, Medicare, Medicare Supplemental, all that sort of thing. Because I assume somewhere in the future there's policy changes that would be much more appropriate if we look at that particular area where people are currently spending their money, and what are they getting for their money. I don't know if that's the charge here, but I wanted to add that.

MR. HACKBARTH: I can't remember if we had data on that in our June report. I believe we did have data on -- so we can pull that out pretty easily for you.